TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
BHF HEALTHCARE, LLC

Respondent Name
HARTFORD UNDERWRITERS INSURANCE

MFDR Tracking Number
M4-18-0403-01

Carrier's Austin Representative
Box Number 47

MFDR Date Received
OCTOBER 16, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: A position statement was not submitted.

Amount in Dispute: $2,820.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Physical and Occupational Therapy Specialty Guide-Part B developed by Novitas Solutions (Medicare Administrative Contract (MAC) for TX) recommends the normal PT session time at 45-60 minutes. The 45-60 minute per session for physical therapy is also based on ODG's general physical therapy treatment protocol."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 10, 2017 July 12, 2017 July 14, 2017 July 17, 2017 July 21, 2017 July 24, 2017 July 26, 2017 July 31, 2017	CPT Code 97110-GP (X 33 units) Therapeutic Procedure	$2,720.00	$1,288.96
July 17, 2017	CPT Code 97530 (X 4 units) Therapeutic Activity	$100.00	$0.00
TOTAL		$2,820.00	$1,288.96

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600, effective March 30, 2014 requires preauthorization for specific treatments and services.
3. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets out the reimbursement guidelines for professional services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 119-Benefit maximum for this time period or occurrence has been reached.
   - 163-The charge for this procedure exceeds the unit value and/or the multiple procedure rules.
   - 168-Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services.
   - 193-Original payment decision is being maintained. Upon review it was determined that this claim was processed properly.
   - W3-Additional payment made on appeal/reconsideration.
   - 247-A payment or denial has already been recommended for this service.
   - 5359-We are unable to process your re-billing, as the documentation does not specify the concern regarding the original analysis. Please re-submit with a copy of the original EOR and a clarification for the basis of the reconsideration.
   - B13-Previously paid. Payment for this claim/service may have been provided in a previous payment.

Issues

1. What is the applicable fee guideline for professional services?
2. Is the denial of payment for physical therapy services supported?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The fee guidelines for disputed services are found in 28 Texas Administrative Code §134.203.

2. According to the explanation of benefits, the respondent denied reimbursement for the disputed physical therapy services based upon "119-Benefit maximum for this time period or occurrence has been reached," "163-The charge for this procedure exceeds the unit value and/or the multiple procedure rules," and "168-Billed charge is greater than maximum unit value or daily maximum allowance for physical therapy/physical medicine services."

   The respondent's position regarding the disputed services is "The Physical and Occupational Therapy Specialty Guide-Part B developed by Novitas Solutions (Medicare Administrative Contract (MAC) for TX) recommends the normal PT session time at 45-60 minutes. The 45-60 minute per session for physical therapy is also based on ODG's general physical therapy treatment protocol."

   Per 28 Texas Administrative Code §134.203(a)(5), "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   In this case, the requestor billed for physical therapy services that exceed the 45-60 minute per session protocol.

   28 Texas Administrative Code §134.203(a)(7) states "Specific provisions contained in the Texas Labor Code or the Texas Department of Insurance, Division of Workers' Compensation (Division) rules, including this chapter, shall take precedence over any conflicting provision adopted or utilized by CMS in administering

the Medicare program. Independent Review Organization (IRO) decisions regarding medical necessity made in accordance with Labor Code §413.031 and §133.308 of this title (relating to MDR by Independent Review Organizations), which are made on a case-by-case basis, take precedence in that case only, over any Division rules and Medicare payment policies."

28 Texas Administrative Code §134.600 (p) states, "Non-emergency health care requiring preauthorization includes: (5) physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels: (A) Level I code range for Physical Medicine and Rehabilitation, but limited to: (i) Modalities, both supervised and constant attendance; (ii) Therapeutic procedures, excluding work hardening and work conditioning."

On June 28, 2017, the requestor obtained preauthorization approval for 12 visits of physical therapy CPT codes 97164, 97110, 97530, 97112, 95851 and 95831.

The division finds that based upon above referenced rules, the respondents preauthorization approval did not specify the number of units on the timed procedures; therefore, the respondent's denial is not supported.

3. Per 28 Texas Administrative Code §134.203(c)(1)(2), "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
(1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83. For Surgery when performed in a facility setting, the established conversion factor to be applied is $66.32.

(2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year. The following hypothetical example illustrates this annual adjustment activity if the Division had been using this MEI annual percentage adjustment: The 2006 Division conversion factor of $50.83 (with the exception of surgery) would have been multiplied by the 2007 MEI annual percentage increase of 2.1 percent, resulting in the $51.90 (with the exception of surgery) Division conversion factor in 2007."

On the disputed dates of service, the requestor billed CPT codes 97110-GP, and 97530-GP. CMS published Medical Learning Network (MLN) Matters, effective January 1, 2011 which states in part "Many therapy services are time-based codes, i.e., multiple units may be billed for a single procedure. The Centers for Medicare & Medicaid Services (CMS) is applying a MPPR to the practice expense payment when more than one unit or procedure is provided to the same patient on the same day, i.e., the MPPR applies to multiple units as well as multiple procedures. Full payment is made for the unit or procedure with the highest PE payment. For subsequent units and procedures, furnished to the same patient on the same day, full payment is made for work and malpractice and 80 percent payment for the PE for services furnished in office settings and other non-institutional settings and at 75 percent payment for the PE services furnished in institutional settings." The multiple procedure rule discounting applies to the disputed service.

To determine the MAR the following formula is used: (DWC Conversion Factor/Medicare Conversion Factor) X Participating Amount = Maximum Allowable Reimbursement (MAR).

Review of Box 32 on the CMS-1500 the services were rendered in zip code 77515, which is located in Angleton, Texas; therefore, the Medicare participating amount is based on locality "Brazoria, Texas".

The 2017 DWC conversion factor for this service is 57.5.

The 2016 Medicare Conversion Factor is 35.8887

Using the above formula and multiple procedure rule (MPR) discounting policy, the Division finds the following:

Code	Medicare Participating Amount	MAR	IC Paid	Amount Due
97110-GP (X33)	$33.17	$53.14 X 33 units and MPR = $1,329.24	$40.28	$1,288.96
97530 (X4)	$35.69	$57.19 X 4 units and MPR = $182.43	$182.43	$0.00

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,288.96.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,288.96 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	11/13/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.